



# Continental American

INSURANCE COMPANY

## Service Request Form

|                    |         |                               |
|--------------------|---------|-------------------------------|
| Certificate Number | Insured | Owner (If other than insured) |
| Address            |         | Phone Number                  |

### 1. Change of Beneficiary (Witness must be someone other than beneficiary)

It is requested that the beneficiary under the above Certificate be changed as follows:

|                        |                         |
|------------------------|-------------------------|
| Primary Beneficiary    | Relationship to Insured |
| Address                |                         |
| Contingent Beneficiary | Relationship to Insured |
| Address                |                         |

### 2. Change of Name (Please attach official document of name change)

|                   |          |
|-------------------|----------|
| Former Name       | New Name |
| Reason for Change |          |

### 3. Change of Address

|                |              |
|----------------|--------------|
| Former Address |              |
| New Address    | Phone Number |

### 4. Transfer of Ownership Request

I request that all benefits, rights and privileges incident to ownership of the policy vested in the new Owner named below, or to such new Owner's executors, administrators and assigns, or successors and assigns.

|                       |                         |
|-----------------------|-------------------------|
| New Owner (Full Name) | Relationship to Insured |
| Address of New Owner  |                         |

### 5. Universal Life Only – Discontinue Premium Deduction Only/Allow Policy to Continue

I request that all payroll deductions or billings be discontinued at this time. I understand that I must notify American Bankers to start payroll deductions or billings at a later date. I understand that my policy will continue to remain in force until all accumulated value capable of continuing the policy is depleted or until I request continuation of premium payments. I understand that once accumulated value capable of continuing the policy is depleted, the policy will lapse.

## 6. Cancellation/Change of Coverage

I have reviewed the benefits of the plan and have decided to cancel my coverage. I understand that by waiving my rights to continue my coverage, I may be required to show evidence of insurability to re-qualify for coverage.

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Short Term Disability  | <input type="checkbox"/> Critical Illness   | <input type="checkbox"/> Other   |
| <input type="checkbox"/> Long Term Disability   | <input type="checkbox"/> employee <input type="checkbox"/> spouse*                                | <input type="checkbox"/> Reduce Face Amount<br>(applies to Critical Illness, Disability,<br>and Universal Life only) |
| <input type="checkbox"/> Hospital Indemnity   | <input type="checkbox"/> Term Life  | <input type="checkbox"/> new face amount employee<br>\$ _____  |
| <input type="checkbox"/> employee <input type="checkbox"/> spouse <input type="checkbox"/> child* | <input type="checkbox"/> employee <input type="checkbox"/> spouse <input type="checkbox"/> child* | <input type="checkbox"/> new face amount spouse<br>\$ _____  |
| <input type="checkbox"/> Cancer   | <input type="checkbox"/> Accident   |  |
| <input type="checkbox"/> employee <input type="checkbox"/> spouse <input type="checkbox"/> child* | <input type="checkbox"/> employee <input type="checkbox"/> spouse <input type="checkbox"/> child* |  |

\*If you have spouse or dependent coverage on the plan(s) you wish to cancel, please specify if you wish to cancel the entire plan or if you want to cancel only a portion of your plan by checking the appropriate boxes above. If you want to cancel your spouse and/or dependents from the plan, please provide their name(s) and date of birth below:

Name(s) and Date(s) of Birth:

## 7. Lost Certificate Notification

I, \_\_\_\_\_ hereby certify that Certificate No. \_\_\_\_\_, dated \_\_\_\_\_, and issued by the Continental American Insurance Company has been lost or destroyed and that said Certificate is not assigned, hypothecated, or pledged in any way whatsoever. I, therefore, request a Certificate of Lost Certificate and agree that should the original Certificate be found or in any way come into my possession, I will return or cause the same to be returned to the Continental American Insurance Company, its successors or assigns. It is distinctly understood and agreed that the original Certificate shall become null and void immediately upon issuance of the Certificate herein requested.

## 8. Loan/Withdrawal Request (Please allow a minimum of 45 days for processing.)

I request a loan of \$ \_\_\_\_\_, or the maximum amount, if less.

## 9. Surrender for Cash Value (Please allow a minimum of 45 days for processing.)

Please note: Your Certificate must accompany this request. If unavailable, Section 7 of this form MUST be completed. I request payment of the cash value in exchange for surrender of the attached Certificate. No bankruptcy proceedings are outstanding against me and no liens are pending against the Certificate, except as follows:

## Sign and Date Here for Above Requests

|                                       |   |
|---------------------------------------|---|
| Date                                  | Signature of Owner                            |
| Address                               |   |
| Witness                               |   |
| Signature of Assignee (if applicable) | Signature of Irrevocable Beneficiary (if any) |

## Request for Service

**Mail:**  
Continental American Insurance Company  
PO Box 427  
Columbia, SC 29202

**Fax:**  
(803) 799-7737

**Phone:**  
(800) 433-3036